

Community Connections

Local solutions for an ailing health care system

By John Ginn

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Don't let the picture painted of Canadian health care by Michael Moore in his film "Sicko" fool you. While Canada's health care system is the envy of many beyond our country's borders, it is in crisis. It's been in crisis for a number of years, a trend that shows no sign of reversing.

The current model of health care service delivery is dramatically escalating in cost to the Canadian taxpayer and becoming increasingly strained in terms of primary and emergency care. Wait times for the simplest of procedures and for more complicated, tertiary institutionalized care continue to grow. Yet our population, anchored by a rapidly aging baby-boom generation, has more complicated medical needs and requires greater levels of both information and care.

If health care is not to continue deteriorating beneath these pressures, it is paramount that we look outside the current model to a wider range of options for both more efficient service delivery and improved health care outcomes.

This will require a change in mindset. Our health care system has arguably the highest level of institutionalized care in the Western world. It is now possible to provide a number of traditionally institutional services in smaller, decentralized community settings. Self-managed care; disease prevention and health promotion; community support; non-traditional approaches to long-term care, mental health, and rehabilitative services; early intervention and prevention strategies; virtual health care – these are but a few of the cutting-edge possibilities available to those brave enough to embrace them.

By bringing these services closer to where patients and their families live, work, and play, by delivering them in more personal and tailored settings – whether through co-operatives or private firms, by for-profit or nonprofit means – not only will we see better outcomes, we will see a reduction in burdens now facing the existing system.

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Online Support of Health Care Self-Management

Seven years ago, during a busy weekend shift working in the emergency department of Nova Scotia's Dartmouth General Hospital, I took special note of the appearance back-to-back of two patients with congestive heart

disease. As they coughed and struggled for breath, they surprised me by croaking out my first name in greeting. I realized that I had seen both of them recently in emergency, for much the same reasons, and both had remembered me.

I took their current history and reviewed their medical records. A notable lack of communication between in-hospital providers, family doctors, and patients had evidently contributed to these patients becoming ill again and requiring rapid re-admission to hospital. I went home the next morning struggling with a health care system that wasn't helping many people get better. It was one more concern to add to those that had been accumulating and festering over my 11-year career to date.

I set out to research these concerns, to get to their root causes and determine their actual impact on both patients and the system in general. I noted that a significant percentage of health care costs in North America were spent on patients with chronic disease and long-term illness. These costs continue to grow with the higher rates of such diseases as diabetes, asthma,

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hypertension, and arthritis, all exacerbated by aging baby-boomer demographics. I also noted that with an increasing list of uninsured and de-listed medical procedures, physicians are not generally compensated to provide preventative support or counselling to these patients.

On the other hand, many research studies prove that when we provide self-help options and opportunities for self-management we help patients improve their health status, and in doing so decrease overall health care costs. In 1993, Dr. Robert Frenck, now director for the UCLA Center for Vaccine Research, passionately argued that "the self care movement is predicated on the notion that every individual is a fundamental human resource for its own care." The Wagner Chronic Disease Management Model (since adopted by many health care

organizations across North America), along with the World Health Organization, the Institute of Medicine in the U.S., and other reputable groups clearly provides support for patient education, participation in decisions, and self-management.

It became clear to me that computer and internet technology, two of my enthusiasms, could offer a solution here. More patients and their families were looking for on-line tools to help them make better health care choices. My first response to this interest was a research web portal and network for chronic disease patients and their physicians, HealthInfoRx. It has since grown into a longer-term solution now called the Connecting People for Health Co-operative (CPHCi).

Two factors drove my intention to create a real live health care and wellness source. First, it was my hope to provide Canadians with a better system for patients and their families to make their own health care decisions. Second, the Nova Scotia Co-operative Council, a not-for-profit organization representing co-operatives across the province, wanted to enhance health care services to their members.

To determine the extent of a health care need that we could address, HealthInfoRx tested the web portal prototype with Crohn's Disease and Colitis patients. One connection that developed between three women exemplified how the internet community that we aimed to establish could support people in need.

Two women with Crohn's took notice of a younger woman recently diagnosed with the disease. She had had some difficulty accepting the changes in her life, combined with the stresses of work and family. While on the wait list for psychological assistance, she sought support on-line. The two older women noticed her stress in chat groups and connected to her directly by our on-line web messaging tool. Their virtual "helping-hands" helped her find out how to cope with Crohn's. With their support, as well as that which the health care system eventually provided, the woman has had more personal tools to manage her condition and integrate with the community than if she had followed the usual path.

Evidence like this drew us to conclude that virtual communities of support, backed with on-line guidance and moderation from health providers, could provide conjunctive and quicker support than traditional methods alone.

CPHCi is now an on-line self-managed family health clinic that enables subscribers to be more directly involved in and have more control over health-related issues affecting themselves and their families. The organization will provide subscribers with secure access to health care professionals, peer group support, personal health records, data tracking and management tools, prescription refill services, and discounted medical supplies.

Market research undertaken by Corporate Research Associates of Halifax on behalf of CPHCi found that Canadians see the internet as a tool they can use to improve communication

and choice in their own health care situations. Consumers want to actively manage their health care through a combination of on-line, phone, and nurse triage services. Consumers want personalized care and information from their doctor, delivered by the most effective media: face-to-face interaction, the phone, or the internet. With the current health care delivery system over-burdened and facing higher costs, options for self-managed and more efficient care such as those available through CPHC*i* will strengthen and enhance the existing system.

The Personal Touch

In 1978, noted Johns Hopkins behavioural scientist Dr. Ivan Barofsky observed that “self-care serves at least four functions: to alleviate illness, to alleviate symptoms, to prevent diseases and to regulate bodily processes.” So, for well over 30 years, a number of health care self-management examples have infiltrated the traditional delivery model. Though not yet commonplace, the number of experiments has increased in recent years.

Several studies have provided evidence that self-managed or community-based disease management programs can reduce overall service delivery costs and improve patient outcomes from chronic diseases. One example comes from a study published by the Canadian Medical Association in 2003.

The study looked at a Toronto-based inner-city Disease Management Program for post-myocardial infarction patients. Administered by home health nurses, this program improved the outcomes for angina and congestive heart failure sufferers and decreased their need for hospitalization. It also lowered the number of emergency room visits and significantly reduced claims for therapeutic, laboratory, and diagnostic services. It concluded that “the augmentation of community care infrastructure, strengthening the communication links between family physicians and cardiac-trained nurses, and reimbursing the providers” were a strong step toward improving patient outcomes and lowering hard costs to the system.

When I look back to my experience with the two cardiac patients at the Dartmouth General, I wish there had been such a program for them. Time and time again, more personalized, de-institutionalized care, which gives patients and their families more information and greater choice, is proving to be a better way for Canadians. Consider some of the following examples.

Self-management is central to the resolution of patient confusion in medication usage. Health Canada recently reported that 19-28% of hospital admissions for patients over the age of 50 are due to complications to medication and to confusion in self-administration. In this vein (pun thoroughly intended), the Canadian Pharmacists Association proposed a

Wellness Program in 2001. In their presentation to the Romanow Commission, they proposed that in these sessions “pharmacists would review medications being taken, discuss disease management and teach people to use devices such as inhalers and blood glucose meters.” This idea seems to be gaining traction. Pharmacists are arguably the most contacted health advisors for everyday self-help. Coupled with additional self-help approaches for patients, their proposal would logically improve patient outcomes.

Lack of information can also cause complications in the treatment of a patient's progress. Recognizing this, a recent project in Nova Scotia introduced “patient navigators” to the provincial health care system. These navigators, most of them registered nurses, help newly-diagnosed patients understand the road ahead and help manage care when appropriate. They work not only with the patients themselves but also with family members, family doctors, and support groups within the patient's community to provide consistent direction, advice, and

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to ease their post-diagnostic transition. A study conducted by Cancer Care Nova Scotia found that “patients didn't know where to find information and how to wend their way through the province's complex and often convoluted cancer care system.” In partnership with the Nova Scotia government, this community-level solution targeted a problem and has improved health outcomes in the process.

The shift from institutionalized care to outpatient or community-based models has also shortened hospital stays while improving the long-term outlook of eating disorder patients in British Columbia. In the early 1990s, Vancouver's St. Paul's Hospital recognized that their traditional model of inpatient care was not allowing health professionals to prioritize the most serious anorexia nervosa cases. The wait lists for treatment consequently escalated beyond reasonable limits.

They began shifting their focus to outpatient therapy – setting up local support services to provide follow-up for their patients. This new direction reduced the average institutional length of stay from 54 to 19 days, which in turn allowed the most serious cases to be given the highest priority in treatment and care.

The training of new doctors has witnessed similar changes. First- and second-year medical students at the University of Western Ontario have had a community component in their education for the last several years. First-year students visit patients with chronic illnesses in their homes and are able to see for themselves support mechanisms within the community and how the patients function in a non-institutional setting. Groups of second-year students are tasked to various

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community agencies to assist in developing and implementing outcome-improvement strategies. The school recognizes that local support services and care options are “important pillars of the health care system.” The next generations of doctors will be well-versed in the difference between tailored health care solutions and hospitalization.

Emergency Care

The common thread within most of the previous examples is the hospital. Despite the growing movement to de-institutionalize patient care, responsibility and ownership continue to rest largely with traditional health care institutions. There are, however, many independent clinics and community health centres that have assumed some of this responsibility.

Ottawa’s Riverside Urgent Care Centre offers services found in your average emergency room, but with two significant differences. Wait times for examination are virtually non-existent and X-ray and laboratory services provide turn-around

in less than an hour on average. What’s most notable though is that, due to lower overhead costs, Riverside can provide these fast services at dramatically less expense than its institutional counterparts.

Hospital emergency rooms are clogged with acute but usually uncomplicated medical problems, such as fractured bones, cuts, and simple infections. While treating these, the Riverside Centre also has facilities for more complicated treatment – from resuscitation to otolaryngology, while providing follow-up and pharmacy services on site as well. It has proven so successful that, within a few years of opening, it treated more patients than any of Ottawa’s ERs (70,000 patient visits in 2000).

While providing top-quality health services to the Orleans community of Ottawa, Riverside Centre has served to reduce overall wait times in Ottawa’s ERs and provide cost-effective health care services for the taxpayer.

Long-Term Residential Care

Perhaps the most challenging factor facing our health care system though, is our rapidly aging population. As baby-boomers become an ever-increasing burden on our institutions, a number of planning problems have arisen. We have issues with wait times, adequate numbers of beds, program funding, long-term care spaces, skyrocketing prescription costs, and service availability in rural jurisdictions.

Given the demand that will likely expand dramatically over the next 20 years, perhaps the most critical of these pending issues for baby-boomers is seniors’ residency. Is there room here also to adopt more locally-controlled options? I suggest it’s time to look outside that box again.

There is a growing push across the country to establish multidisciplinary community teams to assist in the creation of recurrent home care of elderly and critically ill patients. Health professionals from community agencies, partnered with case managers, nurse practitioners, and trained family members are being integrated in several jurisdictions to limit the trauma of institutional care and allow patients to remain in their own homes.

There are several studies that have observed the negative health effects on patients who are removed from environments that are comfortable to them. It doesn’t require a degree from Johns Hopkins to recognize that separation from partners and loved ones, coupled with inevitable confusion, will often lead to rapid deterioration. There are additional studies to support how the training of family members in health management will lead to improved outcomes for the relative they care for. There is a role here, as well, for local providers to assist in this training and in ongoing support for the families.

Perhaps one of the most novel approaches attempted in recent years is the FolkStone model adopted in several communities in British Columbia. Established by PLEA Community Services Society (Vancouver) in 2000, FolkStone provides cost-effective residential care but not in the traditional way that your parents or grandparents might have experienced. It advertises itself as “a warmer, gentler alternative to traditional institutional settings.” The goal is to provide residency and service for the patient in communities that are familiar to them, in private homes, with real families.

This nonprofit program supports these family-run homes with social workers, nutritionists, registered nurses, and other geriatric specialized health professionals as needed. Residents here exercise as much control over their lives as possible and continue to participate in community activities with familiar people and surroundings. This unique and creative service is making waves nationally for its progressive take on elder care and its determination to improve health outcomes through local initiative. Outside the box, indeed.

The Dialogue of Change

There are several groups across the country that provide on-line patient portals and self-management opportunities. Many are institutionally driven and often are dependent on ongoing direct government funding or from research initiatives. Local, grassroots initiatives that are independently funded and self-sustaining are present but more difficult to come by. In my opinion, in time there will be a convergence of these initiatives as a swell in grassroots interest and opinion starts to shape the design, functionality, and economics of these online IT health and promotion portals.

No one solution is perfect. There is no magic pill to save the day. Our health care system remains sick – critically so, some argue. By embracing the current edge of community-level practice several of these symptoms can be treated and perhaps cured. Naturally, growing pains are inevitable when new tactics, treatments, and technologies are employed. When we flip the current health care service delivery model on its head, re-examine old attitudes, and adopt novel approaches, there will always be naysayers. What will also happen, though, is that a dialogue will commence and will continue to the benefit of patients and communities as more efficient and effective outcomes are achieved.



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Community Health Centres ... a solution to Primary Health Care Reform

Established in 1995, the Canadian Alliance of Community Health Centre Associations (CACHCA) provides support to Canada’s provincially-based community health centre organizations and represents the interests of those organizations at the national level.

It is CACHCA’s objective to work for improved health services for individuals and their families in communities across Canada by promoting community health centres as a cost-effective and successful method for delivering primary health care.



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